

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07233

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Leonardtown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Compton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>Jerrie Miles Brotemarkle</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1936</b>
9. AGE (In years last birthday) <b>21</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>9</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Iowa</b>	
11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Marion Everett Brotemarkle</b>		14. MOTHER'S MAIDEN NAME <b>Mable Ann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>8/4/54 to 478-36-2382</b>	
17. INFORMANT <b>Mr Marion E. Brotemarkle</b>		Address <b>Compton, Md.</b>	
18. CAUSE OF DEATH (Only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BROKEN NECK</b> 825x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>auto accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>2:11 p.m. 6-14-58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 295</b>	20f. (City or town) (County) (State) <b>Leonardtown St Mary's Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Wm D Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>6/14/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/17/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtown, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DATE JUN 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Clarke</b>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOT STATE  
HEALTH DEPT.

NAME OF DECEASED  
JAMES J. JENNISON  
AGE  
65  
SEX  
M  
RACE  
W

RESIDENCE  
1000 N. WASHINGTON ST.  
BALTIMORE, MD.

DATE OF DEATH  
JAN. 10, 1933  
TIME OF DEATH  
11:00 AM

PLACE OF DEATH  
HOME

CAUSE OF DEATH  
CORONARY THROMBOSIS

MANNER OF DEATH  
NATURAL

DECEASED'S PRESENT CONDITION  
GOOD

DECEASED'S PRESENT CONDITION  
GOOD

DECEASED'S PRESENT CONDITION  
GOOD

DECEASED'S PRESENT CONDITION  
GOOD

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7236 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07234**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b>		c. LENGTH OF STAY IN 1b <b>6hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Rural Lexington Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USNAS Patuxent River, Maryland</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Allan Buren Hill</b>				4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 5, 1892</b>		9. AGE (In years last birthday) <b>65</b> yrs.	
				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Air Station</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WWI</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Evelyn M. Hill 28 Gardner Ave. Middletown</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				New York immediate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>William D. Boyd</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6/29/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Andrew's</b>	
				22d. LOCATION (City, town, or county) <b>Leonardtwn, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtwn, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>W. Clarke</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON HAS BEEN EXAMINED BY THE PHYSICIAN AND FOUND TO BE IN GOOD HEALTH AND FIT TO SERVE IN THE ARMY.

PLACE CONTINUATION

NAME OF MAN

W. J. Smith

Washington Park

St. Louis

1111 Missouri River, Maryland

ALLAN

WILLIAM

WILLIAM

Wife - White

Wife - White

Wife - White

Wife - White

Wife - White

Wife - White

Wife - White

Wife - White

Wife - White

Wife - White

Wife - White

Wife - White

Wife - White

Wife - White

Wife - White

Wife - White

WILLIAM J. SMITH

WILLIAM J. SMITH

WILLIAM J. SMITH

WILLIAM J. SMITH

WILLIAM J. SMITH

WILLIAM J. SMITH

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G231 7-3-58 et

7237

## CERTIFICATE OF DEATH

07235

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b> <b>Piney Point</b> c. LENGTH OF STAY IN b <b>4 days</b> <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Piney Point</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nace</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1912</b>
9. AGE (In years lost birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>9</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bud Jordon</b>		14. MOTHER'S MAIDEN NAME <b>Jane Fenwick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Jerry Jordon</b>		Address <b>Piney Point, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis and hypertension</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15, 1958</b> , to <b>June 17, 1958</b> , that I lost sow the deceased olive on <b>June 18, 1958</b> , and that death occurred at <b>10 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Graet Mills, Md</b> DATE SIGNED <b>June 24/58</b> ACTUAL SIGNATURE <b>P.J. Bean</b> M.D. PHYSICIAN'S NAME (Type) <b>P.J. Bean M.D.</b> <b>Graet Mills, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/23/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. George's</b>		22d. LOCATION (City, town, or county) (State) <b>Valley Lee, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 24 '58</b>	
ADDRESS <b>Leonardtwn, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>W. Clarke</b>	

CERTIFICATE OF DEATH

2000

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
John Doe		Male		45		Jan 1, 1910		Baltimore, Md.		Jan 15, 1955		Baltimore, Md.		Heart disease		Natural		J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1955	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Telephone		20. Signature of informant		21. Signature of registrar		22. Date of registration		23. Date of registration		24. Date of registration	
John Doe		Son		1234 Main St.		Baltimore		Md.		21201		(410) 555-1234		John Doe		J. Doe, M.D.		Jan 15, 1955		Jan 15, 1955		Jan 15, 1955	



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7238 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Charlotte Hall</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Clinton</b> <b>16X-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>RFD. 1 Box 474</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Lee</b> Last <b>Mangum</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 30, 1938</b>
9. AGE (In years last birthday) <b>19</b> yrs.		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>2</b> Hours <b>0</b> Min. <b>0</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenters Helper</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter L. Mangum</b>		14. MOTHER'S MAIDEN NAME <b>Grace Oliver Tubbs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Walter L. Mangum Clinton, Maryland</b>	
17. INFORMANT <b>Walter L. Mangum</b>		Address <b>Clinton, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DROWNING</b> <b>929.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>IMMED.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>DECEASED WAS POOR SWIMMER - GOT OUT IN WATER OVER HIS HEAD</b>	
20c. TIME OF INJURY Month, Day, Year <b>3:30 p.m. 6/1/58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Patuxent River</b>	20f. (City or town) (County) <b>St. Mary's Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Wm D Boyd</b>		DATE SIGNED <b>6/1/58</b>	
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/4/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hanlon Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 3 '58</b>	
ADDRESS <b>3831 George Ave. Washington, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Alberich</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
323 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: ☐ Male ☐ Female

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Usual Residence: \_\_\_\_\_

7. Date of Death: \_\_\_\_\_

8. Time of Death: \_\_\_\_\_

9. Cause of Death: \_\_\_\_\_

10. Manner of Death: \_\_\_\_\_

11. Signature of Examiner: \_\_\_\_\_

12. Signature of Physician: \_\_\_\_\_

13. Signature of Coroner: \_\_\_\_\_

14. Signature of Medical Officer: \_\_\_\_\_

15. Signature of Health Officer: \_\_\_\_\_

16. Signature of Registrar: \_\_\_\_\_

17. Signature of Clerk: \_\_\_\_\_

18. Signature of Nurse: \_\_\_\_\_

19. Signature of Assistant: \_\_\_\_\_

20. Signature of Stenographer: \_\_\_\_\_

21. Signature of Typewriter: \_\_\_\_\_

22. Signature of Messenger: \_\_\_\_\_

23. Signature of Janitor: \_\_\_\_\_

24. Signature of Cook: \_\_\_\_\_

25. Signature of Laundry: \_\_\_\_\_

26. Signature of Housekeeper: \_\_\_\_\_

27. Signature of Gardener: \_\_\_\_\_

28. Signature of Carpenter: \_\_\_\_\_

29. Signature of Painter: \_\_\_\_\_

30. Signature of Electrician: \_\_\_\_\_

31. Signature of Plumber: \_\_\_\_\_

32. Signature of Blacksmith: \_\_\_\_\_

33. Signature of Shoemaker: \_\_\_\_\_

34. Signature of Tailor: \_\_\_\_\_

35. Signature of Hatter: \_\_\_\_\_

36. Signature of Druggist: \_\_\_\_\_

37. Signature of Apothecary: \_\_\_\_\_

38. Signature of Pharmacist: \_\_\_\_\_

39. Signature of Chemist: \_\_\_\_\_

40. Signature of Physician: \_\_\_\_\_

41. Signature of Surgeon: \_\_\_\_\_

42. Signature of Dentist: \_\_\_\_\_

43. Signature of Optician: \_\_\_\_\_

44. Signature of Podiatrist: \_\_\_\_\_

45. Signature of Veterinarian: \_\_\_\_\_

46. Signature of Botanist: \_\_\_\_\_

47. Signature of Zoologist: \_\_\_\_\_

48. Signature of Geologist: \_\_\_\_\_

49. Signature of Meteorologist: \_\_\_\_\_

50. Signature of Astronomer: \_\_\_\_\_

51. Signature of Historian: \_\_\_\_\_

52. Signature of Philologist: \_\_\_\_\_

53. Signature of Philosopher: \_\_\_\_\_

54. Signature of Theologian: \_\_\_\_\_

55. Signature of Jurist: \_\_\_\_\_

56. Signature of Economist: \_\_\_\_\_

57. Signature of Sociologist: \_\_\_\_\_

58. Signature of Psychologist: \_\_\_\_\_

59. Signature of Physiologist: \_\_\_\_\_

60. Signature of Anatomist: \_\_\_\_\_

61. Signature of Physiologist: \_\_\_\_\_

62. Signature of Pathologist: \_\_\_\_\_

63. Signature of Microscopist: \_\_\_\_\_

64. Signature of Bacteriologist: \_\_\_\_\_

65. Signature of Hygienist: \_\_\_\_\_

66. Signature of Sanitarian: \_\_\_\_\_

67. Signature of Public Health Officer: \_\_\_\_\_

68. Signature of Health Officer: \_\_\_\_\_

69. Signature of Registrar: \_\_\_\_\_

70. Signature of Clerk: \_\_\_\_\_

71. Signature of Nurse: \_\_\_\_\_

72. Signature of Assistant: \_\_\_\_\_

73. Signature of Stenographer: \_\_\_\_\_

74. Signature of Typewriter: \_\_\_\_\_

75. Signature of Messenger: \_\_\_\_\_

76. Signature of Janitor: \_\_\_\_\_

77. Signature of Cook: \_\_\_\_\_

78. Signature of Laundry: \_\_\_\_\_

79. Signature of Housekeeper: \_\_\_\_\_

80. Signature of Gardener: \_\_\_\_\_

81. Signature of Carpenter: \_\_\_\_\_

82. Signature of Painter: \_\_\_\_\_

83. Signature of Electrician: \_\_\_\_\_

84. Signature of Plumber: \_\_\_\_\_

85. Signature of Blacksmith: \_\_\_\_\_

86. Signature of Shoemaker: \_\_\_\_\_

87. Signature of Tailor: \_\_\_\_\_

88. Signature of Hatter: \_\_\_\_\_

89. Signature of Druggist: \_\_\_\_\_

90. Signature of Apothecary: \_\_\_\_\_

91. Signature of Pharmacist: \_\_\_\_\_

92. Signature of Chemist: \_\_\_\_\_

93. Signature of Physician: \_\_\_\_\_

94. Signature of Surgeon: \_\_\_\_\_

95. Signature of Dentist: \_\_\_\_\_

96. Signature of Optician: \_\_\_\_\_

97. Signature of Podiatrist: \_\_\_\_\_

98. Signature of Veterinarian: \_\_\_\_\_

99. Signature of Botanist: \_\_\_\_\_

100. Signature of Zoologist: \_\_\_\_\_

101. Signature of Geologist: \_\_\_\_\_

102. Signature of Meteorologist: \_\_\_\_\_

103. Signature of Astronomer: \_\_\_\_\_

104. Signature of Historian: \_\_\_\_\_

105. Signature of Philologist: \_\_\_\_\_

106. Signature of Philosopher: \_\_\_\_\_

107. Signature of Theologian: \_\_\_\_\_

108. Signature of Jurist: \_\_\_\_\_

109. Signature of Economist: \_\_\_\_\_

110. Signature of Sociologist: \_\_\_\_\_

111. Signature of Psychologist: \_\_\_\_\_

112. Signature of Physiologist: \_\_\_\_\_

113. Signature of Anatomist: \_\_\_\_\_

114. Signature of Physiologist: \_\_\_\_\_

115. Signature of Pathologist: \_\_\_\_\_

116. Signature of Microscopist: \_\_\_\_\_

117. Signature of Bacteriologist: \_\_\_\_\_

118. Signature of Hygienist: \_\_\_\_\_

119. Signature of Sanitarian: \_\_\_\_\_

120. Signature of Public Health Officer: \_\_\_\_\_



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7239 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07237  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>Rural Leonardtown</b>	
3. NAME OF DECEASED (Type or print) First <b>Pauline</b> Middle <b>Mason</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Holly</b>		14. MOTHER'S MAIDEN NAME <b>Apollina Barnes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT Address <b>Wilmer Mason Leonardtown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary occlusion</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William D. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>		DATE SIGNED <b>6/17/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/20/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Our Lady's</b>	22d. LOCATION (City, town, or county) (State) <b>Medley's Neck, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		24a. REC'D BY REGISTRAR <b>JUN 20 1958</b>	
ADDRESS <b>Leonardtown, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: Mary's  
RESIDENCE: 123 Main St, Boston, Mass.

DATE OF DEATH: 10/15/1918  
PLACE OF DEATH: Home

AGE: 45  
SEX: Female

CAUSE OF DEATH: Influenza  
MANNER OF DEATH: Natural

DATE OF EXAMINATION: 10/15/1918  
PLACE OF EXAMINATION: Home

SIGNATURE OF EXAMINER: J. J. [illegible]  
OFFICE OF THE MEDICAL EXAMINER, BOSTON

TESTIMONY OF PHYSICIAN: [illegible]  
DATE: 10/15/1918

TESTIMONY OF NEAREST RELATIVE: [illegible]  
DATE: 10/15/1918

TESTIMONY OF BURIAL OFFICIAL: [illegible]  
DATE: 10/15/1918

TESTIMONY OF OTHER WITNESSES: [illegible]  
DATE: 10/15/1918

TESTIMONY OF OTHER WITNESSES: [illegible]  
DATE: 10/15/1918

TESTIMONY OF OTHER WITNESSES: [illegible]  
DATE: 10/15/1918

TESTIMONY OF OTHER WITNESSES: [illegible]  
DATE: 10/15/1918

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7240 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07238

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Marys</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cape St. Marys</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD Mechanicsville, Md.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <span style="float: right;">47x-3</span> d. STREET ADDRESS <b>2917 - W. St. S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CHARLES</b> - Middle <b>-</b> Last <b>MAYLON</b>				<b>4. DATE OF DEATH</b> <b>June 15, 1958</b> Month Day Year					
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>April 28, 1895</b>		<b>9. AGE</b> (In years last birthday) <b>63</b> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Ret. Gen. Officer</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>US Air Force</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>New York</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Unknown</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW 2</b>				<b>16. SOCIAL SECURITY NO.</b> <b>2917- W. st. S.E.</b>				<b>17. INFORMANT</b> <b>Mrs. Maylon - Washington, D.C.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Drowning</b> <b>850.X</b> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <b>850.X</b> <b>DUE TO (b)</b> <b>DUE TO (c)</b>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>immediate</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>none</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from small boat- unable to return to boat</b>				<b>20c. TIME OF INJURY</b> Month, Day, Year <b>10:05 a.m. 6/15 1958</b>	
<b>20d. INJURY OCCURRED</b> <b>While at work</b> <input type="checkbox"/> <b>Not while at work</b> <input checked="" type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Patuxent River</b>				<b>20f. (City or town) (County) (State)</b> <b>Cape St. Marys, St. Marys Md.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								<b>DATE SIGNED</b> <b>6/15/58</b>	
<b>ACTUAL SIGNATURE</b> <i>William D. Boyd</i>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>EXAMINER'S NAME (Type)</b> <b>William D. Boyd, MD</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>6/19/58</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>		<b>22d. LOCATION (City, town, or county) (State)</b> <b>Arlington, Va.</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.W. Chambers</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUN 18 '58</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <i>W. W. Chambers</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
John Doe		45		Male		White		1912		New York	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM	
123 Main St.		Teacher		Heart Disease		Natural		None		None	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		CHILDREN		SIBLINGS	
Jan 1, 1867		New York		High School		Married		3		2	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM	
Jan 1, 1912		New York		Heart Disease		Natural		None		None	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		CHILDREN		SIBLINGS	
Jan 1, 1867		New York		High School		Married		3		2	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07239

7241

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>St/ Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St/ Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Avenue</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Rural</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Anthony</b> Last <b>MORRIS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>25 March 1952</b>	
9. AGE (In years last birthday) <b>6</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles S. Morris</b>				14. MOTHER'S MAIDEN NAME <b>Ruth A. Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Charles S. Morris</b>		Address <b>Avenue, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>156.1 Carcinoma of Liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 months</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 17, 1958</b> , to <b>June 5, 1958</b> , that I last saw the deceased alive on <b>June 5, 1958</b> , and that death occurred at <b>2 P. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William D Boyd</b>				ADDRESS (Street, city or town, state) <b>Chaptico, Md</b>			
PHYSICIAN'S NAME (Type) <b>William D Boyd</b>				DATE SIGNED <b>6 June 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9 June 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		22d. LOCATION (City, town, or county) (State) <b>Bushwood Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson</b>				ADDRESS <b>Leonardtwn, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 12 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Atchison</b>			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

• **LF**, 1405V



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7242 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08368

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL) Chesapeake Bay area		c. LENGTH OF STAY IN 1b 15 mos.	
6.7 miles 135 degrees d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) from NAS, Patuxent River, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River,	
		d. STREET ADDRESS U.S. Naval Air Station	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Glyn Theodore THORESTON		4. DATE OF DEATH Month Day Year June 2 1958	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 9, 1930
9. AGE (In years) 28 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Aviator		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Montana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Glyn THORESTON		14. MOTHER'S MAIDEN NAME Edith CORA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 9/50 to 6/58		16. SOCIAL SECURITY NO. 3325-26-517	
17. INFORMANT Wife: Dolores M. Thoreston, Box 91, Mt. Hamilton Rd., San Jose, Calif.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INJURIES, MULTIPLE, EXTREME 860X DUE TO (Only small parts of remains recovered) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Immediately	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparent explosion or disintegration of jet aircraft.	
20c. TIME OF INJURY Month, Day, Year 9:40xxx June 2, 1958		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay	
20f. (City or town) St. Mary's, Maryland		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> (All tissue sent to Armed Forces Pathological Institute, Washington, DC)			
ACTUAL SIGNATURE WM. D. BOYD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) W. S. WRAY, CAPT MC USN		DATE SIGNED 18 June 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/22/58	
22c. NAME OF CEMETERY OR CREMATORY Golden Gate National		22d. LOCATION (City, town, or county) (State) San Bruno, California	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR JUL 21 '58 24b. REGISTRAR'S SIGNATURE W. S. WRAY	

7742

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		LOCALITY		OCCUPATION	
EDUCATION		RELIGION		MARITAL STATUS	
SINGLE		MARRIED		WIDOWED	
DIVORCED		SEPARATED		OTHER	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
COUNTRY OF BIRTH		STATE OF BIRTH		COUNTY OF BIRTH	
DATE OF ENTRY INTO STATE		PLACE OF ENTRY		CITY OF ENTRY	
COUNTRY OF ENTRY		STATE OF ENTRY		COUNTY OF ENTRY	
DATE OF DEPARTURE FROM STATE		PLACE OF DEPARTURE		CITY OF DEPARTURE	
COUNTRY OF DEPARTURE		STATE OF DEPARTURE		COUNTY OF DEPARTURE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		LOCALITY		OCCUPATION	
EDUCATION		RELIGION		MARITAL STATUS	
SINGLE		MARRIED		WIDOWED	
DIVORCED		SEPARATED		OTHER	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH	
COUNTRY OF BIRTH		STATE OF BIRTH		COUNTY OF BIRTH	
DATE OF ENTRY INTO STATE		PLACE OF ENTRY		CITY OF ENTRY	
COUNTRY OF ENTRY		STATE OF ENTRY		COUNTY OF ENTRY	
DATE OF DEPARTURE FROM STATE		PLACE OF DEPARTURE		CITY OF DEPARTURE	
COUNTRY OF DEPARTURE		STATE OF DEPARTURE		COUNTY OF DEPARTURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07240

7243

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. LENGTH OF STAY IN 1b <b>10 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hermansville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph F. Unkle</b>				4. DATE OF DEATH Month Day Year <b>June 4 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>Jan. 1, 1878</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William Unkle</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Osborne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>-----</b>				16. SOCIAL SECURITY NO. <b>214-16-7757</b>		17. INFORMANT <b>Benjamin O. Unkle</b> Address <b>St. Inigoes, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Basal cell carcinoma (neck) with metastases to lungs &amp; kidney</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>4 years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>August 1954</b> , to <b>June 4 1958</b> , that I last saw the deceased alive on <b>June 4 1958</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Great Mills, Md.</b> DATE SIGNED <b>6/5/58</b>							
ACTUAL SIGNATURE <b>P. J. Bean MD</b> M.D. <b>Great Mills, Md.</b>							
PHYSICIAN'S NAME (Type) <b>P. J. Bean, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/7/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Face</b>		22d. LOCATION (City, town, or county) (State) <b>Great Mills, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. B. Robinson</b>				ADDRESS <b>Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 12 58</b>	
						24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

